New York Law Journal
SERVING THE BENCH AND BAR SINCE 1888
VOLUME 234—NO. 89 NEW YORK LAW JOURNAL Monday, November 7, 2005
Web address: http://ww

OUTSIDE COUNSEL

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Litigation Involving the Noncompliant Patient

Caring for a patient who insists on engaging in unhealthy activity is a challenge that many physicians address on an all-too-frequent basis.

Because of the current legal landscape, defending a physician sued by such a patient presents a similarly challenging endeavor.

Despite the obstacles in caring for patients engaging in unhealthy behavior and the obvious increased risk of a medical catastrophe, courts have traditionally limited the availability of the culpable conduct defense in medical malpractice litigation to situations involving patient noncompliance or failure to reveal historical information.[1]

The rationale for such a restrictive approach to culpable conduct in the medical malpractice context has historically been based either on analogy to the particularly susceptible patient/eggshell skull doctrine, or on the notion that the injury and the patient's conduct are the result of separate and discrete events in which the patient's conduct relates only to the extent of the injury, such as an automobile accident and a failure to wear seatbelts.

This approach lacks persuasive support and it behooves the legal analyst to re-examine the rationale supporting the historical judicial reluctance to include unhealthy activity as a form of culpable conduct.

Historic Considerations

Comparative negligence or culpable conduct is defined in much the same way as is negligence of a defendant; that is the lack of ordinary care or a failure to use that degree of care that a reasonably prudent person would have used under the same circumstances.[2] Just as with negligence of a defendant, comparative negligence of a plaintiff can arise from doing an act that a reasonably prudent person would not have done under the circumstances or from not doing an act that a reasonably prudent person would have done under the circumstances.

In limiting the doctrine of culpable conduct in the context of medical malpractice cases, courts have held that the doctrine does not apply unless the patient has failed to comply with the instructions or recommendations of the defendant physician or has affirmatively misled the physician by providing inaccurate information. Thus, a plaintiff's participation or involvement in an unhealthy activity in and of itself, historically has not served as a sufficient basis for a comparative negligence charge.[3] Thus, one could be the sole author of his own illness and yet the exclusive focus of the verdict sheet would be the care of the defendant physician.

Doctrinal Bases

The bases proffered for this approach are several. First, it has been suggested that activities that took place prior to a physician's negligence should be excepted from the comparative negligence doctrine because they represent conduct that is distinct or separate from the acts causing injury or because the injuries are divisible.[4] Second, it has been argued that the eggshell skull doctrine, which requires that a tort feasor take the victim as he finds him, is applicable in the medical malpractice context, and does not permit a physician treating a patient in a debilitated condition to later accuse the patient of contributing to his own injury due to that condition.[5]

The injury caused by smoking in a failure-to-diagnose lung cancer case, is not easily divisible from any alleged delay in diagnosis and is akin to a general liability scenario.

With respect to the notion that a patient's conduct should be beyond the purview of the doctrine of comparative negligence because the injuries resulting from unhealthy activities are divisible from those caused by the care, such a separation of liability from damages may make sense in the context of certain types of general liability litigation such as a car accident. However, while a conceptual distinction between the act causing liability and the mitigation of damages through the use of seatbelts may exist,[6] in the context of medical care, the acts of the physician and patient are frequently inexorably intertwined, often resulting in exacerbation of a disease process for which relative contributions of patient, doctor and the disease process can not be easily distinguished.

For example, the injury caused by smoking in a failure-to-diagnose lung cancer case, is not easily divisible from any alleged delay in diagnosis and is akin to a general liability scenario, such as a shattered patella resulting from a slip and fall in which both the defendant's conduct in permitting a defect in a sidewalk and the plaintiff's conduct in not watching where one is walking are both considered by the jury in evaluating relative share of liability and contribution to the injury. Unlike the car-accident scenario in which the failure to wear a seatbelt could never in and of itself cause an independent injury, both the slip-and-fall scenario and the delay in diagnosis scenario involve conduct by the plaintiff that could in and of itself cause injury. Neither the slip and fall nor the delay in diagnosis scenarios, fit into the divisible injury construct, or serve as a compelling basis to shield culpable conduct from consideration by the jury.

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With respect to the "eggshell skull" or particularly susceptible plaintiff doctrine, the argument that a tort feasor takes the victim as he finds him presumes that the "victim" did not actively contribute to the creation of his "eggshell skull," and is based on policy considerations involving the spreading of risk to those best able to avoid it.

While the eggshell skull doctrine may further this policy in some general liability scenarios in which the plaintiff had no control over the development or existence of his particular susceptibility, courts seeking to define a physician's role in connection with caring for a patient for a particular condition should not be so myopic as to disregard a patient's role in creating or contributing to the very same condition.[7]

The notion that a patient may be unaware of the dangers of certain unhealthy activities may have made sense at one time, but when it comes to activities such as cigarette smoking, unhealthy foods, lack of exercise, and the like, the public has become acutely aware of the associated dangers. Given this increased public awareness of these dangers, from a societal and policy perspective it makes more sense to permit a jury to assign culpability based on each party's contribution to the disease or ability to avoid injury, notwithstanding that most disease processes by their very nature may have begun to develop before the defendant physician had an opportunity to instruct the patient to refrain.[8]

The advance in social awareness of the dangers of unhealthy activities was tacitly acknowledged in *Elkins v. Ferencz*,[9] in which the First Department initially dismissed a plaintiff's verdict, and later reinstated it and remanded for a new trial because of the trial court's failure to instruct the jury on the issue of comparative negligence.

The decision suggests that the doctrine of comparative negligence may now be available in a medical malpractice case in connection with unhealthy activity and, specifically, the plaintiff's heavy use of prescription drugs and tobacco.[10] While the decision focused primarily on the patient's delay in seeking treatment, her interference with treatment, and her failure to provide an adequate history, the inclusion of the reference to the history of tobacco and heavy prescription drug use as contributing factors in causing plaintiff's disease suggests a shift in thinking as to whether participation in unhealthy activities, that were not traditionally thought of as noncompliance, may be the subject of consideration by a jury on the issue of comparative negligence.

While the majority of decisions in other states restrict the doctrine of comparative negligence in the medical malpractice context to instances of noncompliance as opposed to participation in unhealthy activities,[11] in *Magee v. Pittman*,[12] a well-reasoned decision out of Louisiana, their Court of Appeals held that plaintiff's smoking was properly considered as a factor in allocating 20 percent fault to the plaintiff in connection with a claim of delay in diagnosing his death from heart disease.

Practical Aspects

To the extent that the patient claims a lack of responsibility based on a lack of awareness of the dangers inherent in the unhealthy activity, this position could present a question of fact to be evaluated by the jury. Similarly, to the extent that the plaintiff denies participation in such unhealthy activities, or that the activity did not contribute to the disease process, these positions would represent factual issues to be explored during discovery and at trial through cross-examination of the plaintiff and expert testimony concerning causation. Rather than requiring a finding of noncompliance, the verdict sheet in a case in which comparative negligence is claimed would contain an interrogatory inquiring as to whether the patient was aware of the health risk; and as a matter of causation, whether the health risk contributed to the condition about which plaintiff complains. Thus, in a case involving an alleged delay in diagnosis of lung cancer, the relative contribution of smoking to the disease process would be considered alongside the claim of delay in diagnosis when evaluating the decrease in chance of survival.

It is time courts state what is clear, that many unhealthy activities are known and their dangers common knowledge.

Conclusion

There is no logical rationale for automatically excluding unhealthy activities from consideration by a jury as the basis for a finding of comparative negligence in medical malpractice cases merely because they preceded the medical care in question or because they were not in direct contravention of a physician's order. Trial courts have tacitly acknowledged this flaw by permitting evidence of unhealthy conduct on alternative theories such as life expectancy and alternative causation or permitting the admonition of a nonparty physician to suffice as the basis for the required noncompliance.

This article has examined some of the theoretical and practical considerations in advancing a claim of culpable conduct, based on participation in unhealthy activities, where a physician's order has not been violated.

It is high time that courts further acknowledge what has become painfully clear to society, that unhealthy activities have been identified and their associated dangers have become common knowledge, thereby creating a predicate for culpability as a matter of public policy.

1. *Ooft v. City of New York*, 429 NYS2d 376 (N.Y. Sup. 1980) (involving a patient's failure to convey information that she had an IUD in her womb at the time a second IUD was inserted); *Charell v. Gonzalez*, 673 NYS2d 685 (1st Dept. 1998) (Jury found cancer patient 49 percent at fault in medical malpractice action, where evidence showed patient refused treatment plan recommended to her by oncologists.) For a more detailed and precise analysis of the aforementioned proposition, albeit from a sister state, see *Martineau v. Nelson*, 247 NW2d 409, 415 (Minn. 1976).

2. PJI 2:10 and 2:36

3. See *Suria v. Shiffman*, 67 NY2d 87, 490 N.E.2d 832, 499 N.Y.S.2d 913 (N.Y. 1986) (plaintiff not culpable for allowing nonphysician friend to inject mineral oil into breasts prior to defendant's treatment of patient); *Chodos v. Flanzer*, 90 AD2d 838, 456 N.Y.S.2d 80 (2nd Dept. 1982) (finding any negligence on plaintiff's part in her practice of oral hygiene prior to commencement of treatment was totally irrelevant).

4. See *Schagger v. Pfeiffer*, 244 AD 739, 278 N.Y.S. 949 (2nd Dept. 1935) (ruling that any conduct by plaintiff before the cast was put on could not be considered as a defense in action against physician for applying cast.)

5. Sharon W. Murphy, "Contributory Negligence in Medical Malpractice: Are the Standards Changing to Reflect Society's Growing Health Care Consumerism?," 17 Dayton L. Rev. 151,165 (1991).

6. *Giannetti v. Darling Delaware Carting Co., Inc.*, 666 NYS2d 372 (N.Y. Sup. 1997); *Curry v. Moser*, 454 N.Y.S.2d 311 (2nd Dept. 1982).

7. See Ellen M. Bublick, "Comparative Fault to the Limits," 56 Vand. L. Rev 977, 1018-1020 (2003). ("[Decisions excluding defense of plaintiff's negligence] do not necessarily assign liability based on which party is better able to care for the plaintiff's physical well-being.")

8. "In many cases, the patient could have cared for his health as well as or better than the doctor could have. For example, a patient's decision not to smoke might be as important in preventing an early cancer death as a doctor's prompt detection and treatment of the cancer." Bublick, supra note 7.

9. 263 AD2d 372 (1st Dept. 1999).

10. Id. at 373.

11. See e.g., *DeMoss v. Hamilton*, 644 NW2d 302; *Sendejar v. Alice*, 555 SW2d 879.

12. 761 So.2d 731 (1st Cir. 2001).